Commonwealth of Virginia

State Health Benefits Program Enrollment Form For Retirees, Survivors And LTD Participants

- **Enroll within 31 days of your retirement or long-term disability start date (end of active coverage),** or you may forfeit your only opportunity to participate in the health benefits program.
- **An eligible survivor of a retiree/employee or LTD participant who wishes to continue health benefits coverage** must complete this form within 60 days of the date of death.
- **This form must be signed by the Enrollee (Retiree, Survivor, LTD participant), not by a dependent.** Keep a copy of your completed form for documentation of your enrollment or change.

IF YOU ARE USING THIS FORM TO. . .	COMPLETE PART(S) . . .
• Enroll in plan that coordinates with Medicare	A, B, C, E
• Enroll in Non-Medicare State plan	A, B, D, E
• Enroll in *combination* of plans above	A, B, C, D, E
• Change plans and/or type of membership	A, B, C and/or D, E
• Make an Open Enrollment change (non-Medicare participant only)	A, B, D, E
• Waive or cancel participation in the State Health Benefits Program	F
• Waive coverage in VSDP/LTD due to open enrollment or a qualifying mid-year event, or cancel VSDP/LTD coverage	A, E
• Enroll in Extended Coverage	Obtain a separate Extended Coverage Enrollment Form
• Change your address	A, E

IF YOU ARE A. . . *(check one)*	SEND COMPLETED FORM TO . . .
❑ New Retiree or New Survivor of Active State Employee ❑ New VSDP or other LTD Participant	Your Agency Benefits Administrator
❑ Current VRS Retiree or Survivor* ❑ Current VSDP/LTD Participant* * Including dependents who have separate plans from the Enrollee	Virginia Retirement System P.O. Box 2500 Richmond, VA 23218-2500
❑ All Other Retirees, Survivors, or LTD Participants (Optional Retirement Plan, Local Retiree, etc.)	Your former Agency's Benefits Administrator

Part A. Enrollee Information – (Retiree, Survivor or LTD Participant Information Only – Not Dependent Information)

☐ Check here if this is an address change.

Print Name _____ Social Security Number _____
(First) (M.I.) (Last)

Address _____ City _____ State _____ Zip + 4 _____

Day Time Phone (_____) _____

Birth Date _____/_____/_____ Sex: ☐ Male ☐ Female E-mail Address _____
Month Day Year

REASON FORM IS BEING SUBMITTED *(Check each appropriate category)*

☐ **Initial Enrollment.** *Check one:* ○ Retirement ○ Re-enrolling from dependent status in active/other retiree coverage
○ VSDP or other LTD Initial Enrollment/Waiver ○ Survivor Enrollment

☐ **Now Eligible For Medicare.** ○ Retiree/Survivor ○ Spouse ○ Child ○ VSDP or other LTD Participant

☐ **Open Enrollment (available to Non-Medicare Participants Only) To Change Plans And/Or Membership.**
○ Enrollee/Enrollee and Dependents ○ Dependent with Separate Coverage

☐ **Remove Dependent(s) From My Coverage.** (Change will be effective the first day of the month after this form is received.)
Name of Dependent(s) _____ Social Security Number(s) _____
If you are removing a dependent due to a qualifying mid-year event, please indicate the event on page 2.

☐ **Medicare Eligible Member Making Allowable Plan Change.** (Effective date will be the first of the month after this form is received.)
○ Retiree/Survivor ○ Spouse ○ Child ○ VSDP or other LTD Participant

☐ **Cancel/Waive Coverage (go to Part F.).**

(Part A. continues on page 2)

☐ **Qualifying Mid-Year Event (Life Event).** Check the type of event below, and attach the appropriate supporting information as indicated. Please complete enrollee information in Part B. Submit this change within 31 days of the event. In most cases, the change will be effective the first day of the month following receipt of this form. Changes in membership due to these events allow non-Medicare participants to change plans.

Qualifying Mid-Year Events (Event if applicable/*Attach This Information*) **Date of Event** _____

Events That Are Consistent With Increasing Membership

- ☐ Marriage/*Marriage Certificate*
- ☐ Birth or Adoption/*Birth Certificate or Adoption Agreement*
- ☐ Eligible dependent loses eligibility for Medicare, Medicaid or other government plan/*Government Documentation*
- ☐ Spouse or eligible child loses employer eligibility (including going from full-time to part-time employment)/*Employer Documentation*
- ☐ Spouse begins leave without pay/*Employer Documentation*
- ☐ Spouse or eligible child's loss of eligibility for other group coverage/*Documentation to Support Loss*
- ☐ Judgment, decree or order requiring coverage of an eligible child/*Court Order*
- ☐ Permanent custody granted/*Court Order*
- ☐ Spouse or eligible child's open enrollment or significant change under another employer's plan/*Employer Documentation*

Events That Are Consistent With Decreasing Membership

- ☐ Divorce/*Divorce Decree*
- ☐ Death of spouse or child/*Death Certificate*
- ☐ Child loses eligibility/*Documentation to Support*
- ☐ Judgment, decree or order requiring another party to cover your child/*Court Order*
- ☐ Covered dependent gains eligibility for Medicare or Medicaid/*Government Documentation*
- ☐ Spouse or covered child gains employer eligibility (including going from part-time to full-time employment)/*Employer Documentation*
- ☐ Spouse ends leave without pay/*Employer Documentation*
- ☐ Spouse or covered child's open enrollment or significant change under another employer's plan/*Employer Documentation*

Allows Plan Change

- ☐ Covered participant/dependent moves in or out of plan's service area (non-Medicare only)/*Proof of Move*

TYPE OF MEMBERSHIP

Please select the membership type which best describes the coverage for which you are enrolling:

☐ **Single Coverage** ☐ **Two people** ☐ **Family** – Enrollee with Two or More Dependents

VSDP/LTD Waive or Cancel for existing participants (See Part F. for new participants.):

☐ **VSDP/LTD Waiver of Health Coverage due to State Open Enrollment, or a Qualifying Mid-Year Event** (indicate event above)

☐ **VSDP/LTD Cancellation of Coverage without Open Enrollment or a Qualifying Mid-Year Event**

Part B. Enrollment

List all Medicare and Non-Medicare Enrollees. Include yourself and everyone you are enrolling in a health plan (include all enrollees, not just additions or changes). Attach a copy of Medicare cards for all members who are Medicare-eligible.

Relationship Codes: E = Retiree, LTD or Survivor H = Husband W = Wife S = Son D = Daughter SS = Stepson SD = Stepdaughter O = Other child

NAME	Sex M/F	Birthday MM/DD/YYYY	Social Security Number	Relationship Code	Medicare Information (if applicable)		
					Medicare Claim No.	Part A Effective Date	Part B Effective Date

HEALTH BENEFITS PLAN SELECTION

Members must select a plan based on their Medicare eligibility. Members who are eligible for Medicare, regardless of age, must select a plan in Part C, and those who are not eligible for Medicare must select a plan in Part D. The only exception is for members in Family coverage. In that case, Family coverage may be maintained under COVA Care (in Part D), but Medicare will be primary payor for the Medicare-eligible member(s). Enrollment in a Medicare-coordinating (Medicare primary) plan must take place immediately upon any participant's eligibility for Medicare.

If you are making a plan change, you will only receive new ID cards that have updated information. You may continue using your current cards if there is no change in the information.

Part C. Plans For Retiree Group Participants Eligible For Medicare

If you are eligible for Medicare and have not secured both Hospital Part A and Medical Part B of Medicare, contact your local Social Security Administration office. If you enroll in a plan that includes prescription drug coverage, you will be enrolled in Medicare Part D (if eligible and not already enrolled in another Part D plan.)

Please select a plan below and indicate whether the coverage is for you, your spouse, or a dependent child.*

PLAN	COVERAGE FOR (check all that apply)			
☐ **Advantage 65**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
☐ **Advantage 65 with Dental/Vision**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
☐ **Advantage 65 – Medical Only***	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
☐ **Advantage 65 – Medical Only* with Dental/Vision**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child

** Does not include coverage for outpatient prescription drugs.*

The plans below may be selected only by members currently enrolled in Option I/Medicare Complementary, or Option II/Medicare Supplemental.*

PLAN	COVERAGE FOR (check all that apply)
☐ **Option I**	☐ Retiree/Survivor ☐ Spouse ☐ Child
☐ **Option II**	☐ Retiree/Survivor ☐ Spouse ☐ Child
☐ **Option II with Dental/Vision**	☐ Retiree/Survivor ☐ Spouse ☐ Child

*Dental/Vision coverage may be added to either Advantage 65 or Option II at any time, and it may be canceled at any time. However, once the Dental/Vision option has been elected and canceled one time, it may not be elected again. Participants in Option I or Option II may enroll in Advantage 65 (including Advantage 65 – Medical Only) at any time. However, once enrolled in any Advantage 65 plan, neither Option I nor Option II may be elected again. Except for initial enrollment in a Medicare coordinating plan, these elections/changes are effective the first of the month following receipt of your request .

Part D. Plans For Retiree Group Participants Not Eligible For Medicare (or family groups with some members eligible for Medicare)*

All non-Medicare family members must enroll in the same plan. To ensure in-network coverage, use physicians and facilities that participate in your plan's provider networks.

SELF-FUNDED STATEWIDE PLANS
Administered by the State Retiree Health Benefits Program

❑ COVA HDHP [High Deductible Health Plan] (CHD)

❑ COVA Care Plan (CC0)
❑ COVA Care + Out-of-Network (CC1)
❑ COVA Care + Expanded Dental (CC2)
❑ COVA Care + Out-of-Network + Expanded Dental (CC3)
❑ COVA Care + Vision + Hearing + Expanded Dental (CC4)
❑ COVA Care + Out-of-Network + Vision + Hearing + Expanded Dental (CC5)

REGIONAL FULLY FUNDED HMO (NORTHERN VIRGINIA)

❑ Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO

Note: Kaiser plan members must 1) live or work in the Kaiser service area and 2) select a primary care physician.

**All Medicare eligible family members must be enrolled in Medicare Parts A, B and D for primary coverage.*

Part E. Authorization, Enrollee Statement, And Certification

ENROLLEE STATEMENT: I want to enroll or make an allowable change in the Retiree Health Benefits Program. The cost of coverage will be deducted from my Virginia Retirement System (VRS) retirement benefit. If I am not receiving a VRS monthly benefit, or if my VRS monthly retirement payment is not enough to deduct my health insurance premium, I will be billed directly. To cancel coverage, I must send my request in writing to the appropriate address noted on page 1. Cancellation of coverage will be effective the end of the month in which my written request is received. I understand that notice of cancellation does not relieve me from payment for monthly coverage that has already begun. I understand that if I cancel my state retiree coverage, I will not have another opportunity to enroll in the Retiree Health Benefits Program, and that cancellation of prescription drug and/or Dental/Vision benefits will preclude any future enrollment for those benefits. I understand that my health premiums are subject to change. I am aware that the Commonwealth reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that failure to pay premiums by the date designated on my monthly bill, if applicable, will result in cancellation of coverage and will permanently revoke my eligibility for the program. Further, I understand that no claims will be processed for services during months for which premium payment in full has not been received. I understand that enrolling or maintaining coverage for ineligible dependents may result in removal from the State Retiree Health Benefits Program for up to three years.

CERTIFICATION/AUTHORIZATION: I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the health plan and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Enrollee's Signature[1] _____ **Date** _____

Print Name _____

[1]*Dependents are not authorized to sign this form. It must be signed by the Retiree, Survivor or LTD Participant.*

Part F. To Waive Or Cancel State Coverage

RETIREES AND/OR SURVIVORS

Name _____ Effective Date or Terminate Date _____
(First) (M.I.) (Last) (MM/DD/YYYY)

Social Security Number _____ Telephone Number _____

WAIVE COVERAGE

☐ **I am a retiree and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent qualifying mid-year event, I will be eligible to apply for retiree coverage only within 31 days of that event.

Spouse's Name _____ Spouse's Social Security Number _____

(Part F. continues on page 4)

(PART F. CONTINUED)

CANCEL/DECLINE COVERAGE

☐ **I am a new retiree* and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll except as allowed in **WAIVE COVERAGE** section.
**Includes retirees ending their 12-month severance benefit period.*

☐ **I am a current retiree/survivor and wish to cancel my coverage in the State Health Benefits Program for retirees.** I understand that neither I nor my dependents will be permitted to re-enroll in the program at any time. This serves as my written notification and authorization to cancel my coverage and that of my dependents. This will be effective the first of the month after notice is received.

☐ **I am a retiree who has become eligible for coverage in an active state plan and I wish to cancel my retiree coverage.** I understand that I may re-enroll in the retiree program within 31 days of the loss of active coverage and that I must have maintained continuous coverage in the State program to do so.

If you are entitled to a Health Insurance Credit, waiving or canceling State coverage in no way affects your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature _____ **Date** _____

NEW VSDP/LTD PARTICIPANTS

Name _____ Effective Date _____
(First) (M.I.) (Last)

Social Security Number _____ Telephone Number _____

WAIVE COVERAGE AT START OF LTD (For waiver or cancellation of existing LTD coverage due to State Open Enrollment or a qualifying mid-year event, return to part A.) An Enrollment form must be submitted within 31 days of starting LTD. At any time after enrollment, nonpayment of premiums will result in termination of coverage for the duration of long-term disability.

☐ **I am a new VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll unless I experience a qualifying mid-year event or Open Enrollment. (Open Enrollment is available to non-Medicare participants only).

☐ **I am a VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent qualifying mid-year event, I will be eligible to apply for retiree group coverage only within 31 days of that event.

Spouse's Name _____ Spouse's Social Security Number _____

If you are entitled to a Health Insurance Credit, waiving or canceling coverage does not affect your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature _____ **Date** _____

Agency Approval/Agency Use Only

I understand that the agency Benefits Administrator is responsible for the initial setup of the retiree's, active survivor's or VSDP/LTD participant's record in the Benefits Eligibility System (BES). The agency Benefits Administrator is also responsible for forwarding a copy of the completed Enrollment form to VRS (if VRS is the Benefits Administrator).

Agency Name _____ Agency Number _____ Coverage Effective Date _____

I have reviewed this form, and verified that the retiree, survivor or LTD participant is eligible for the plan or waiver selected. I certify that the information on this form is complete and accurate to the best of my knowledge.

Agency Representative's Signature _____ Date _____

Print Name and Title _____ Phone Number _____

This participant is enrolling as:

☐ Virginia Retirement System Retiree/Survivor ☐ Local Retiree/Survivor ☐ ORP Retiree/Survivor (name of plan) _____
☐ VSDP/LTD Participant ☐ Other LTD Participant ☐ Non-Annuitant Survivor

The participant has been told that the first premium would be in the amount of $ _____

If retiring, indicate type of retirement: ☐ Service Retirement ☐ Disability Retirement Retirement Date: _____

VRS Use Only (For Existing Retiree Group Members)

Date Form Received _____ Effective Date of Change (subject to DHRM approval) _____

For Disability Retirees:

Date of Approval Letter _____ Date of Retirement _____